		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040394

Facility Name: GLENWOOD CARE CENTER

Address: 222 N. HAMMES (Number) JOLIET (City) 60435 (Zip Code)

County: WILL

Telephone Number: (847) 647-1717 **Fax #** (847) 647-0222

IDPA ID Number: 36-3873066

Date of Initial License for Current Owners: 04/01/93

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[X]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: BOB KAGDA **Telephone Number:** (847) 675-3585

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) SHERWIN RAY

(Title) PRESIDENT

Paid Preparer

(Signed) (SEE ATTACHED ACCOUNTANTS' REPORT) (Date)

(Print Name and Title) BOB KAGDA, PARTNER

(Firm Name & Address) KRUPNICK BOKOR KAGDA & BROOKS, LTD, 3750 W DEVON AVE, LINCOLNWOOD, IL 60712-1124

(Telephone) (847) 675-3585 Fax # (847) 675-5777

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	203	Skilled (SNF)	203	74,095	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	203	TOTALS	203	74,095	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			4,524	4,524	8
9	SNF/PED					9
10	ICF	44,332	4,693	814	49,839	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	44,332	4,693	5,338	54,363	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 73.37%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 04/01/93

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 04/01/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 4,524

Medicare Intermediary ADMINASTAR

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	174,575	21,092	13,840	209,507		209,507	1,765	211,272			1
2	Food Purchase		217,413		217,413	(19,874)	197,539	(1,053)	196,486			2
3	Housekeeping	197,686	30,978		228,664		228,664		228,664			3
4	Laundry	59,765	17,410		77,175		77,175		77,175			4
5	Heat and Other Utilities			159,033	159,033		159,033	459	159,492			5
6	Maintenance	53,801	27,021	38,622	119,444		119,444	14,333	133,777			6
7	Other (specify):*			15,474	15,474		15,474		15,474			7
8	TOTAL General Services	485,827	313,914	226,969	1,026,710	(19,874)	1,006,836	15,504	1,022,340			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,658,517	138,791	8,298	1,805,606		1,805,606	35,554	1,841,160			10
10a	Therapy	63,032	14,484	89,302	166,818		166,818	(2,418)	164,400			10a
11	Activities	91,581	5,249		96,830		96,830		96,830			11
12	Social Services	103,924		2,727	106,651		106,651		106,651			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,917,054	158,524	114,727	2,190,305		2,190,305	33,136	2,223,441			16
	C. General Administration											
17	Administrative	95,793		192,000	287,793		287,793	(133,406)	154,387			17
18	Directors Fees											18
19	Professional Services			251,139	251,139		251,139	(192,144)	58,995			19
20	Dues, Fees, Subscriptions & Promotions			50,176	50,176		50,176	(3,244)	46,932			20
21	Clerical & General Office Expenses	106,023	16,145	165,235	287,403		287,403	(98,703)	188,700			21
22	Employee Benefits & Payroll Taxes			401,150	401,150	19,874	421,024		421,024			22
23	Inservice Training & Education			4,191	4,191		4,191	1,110	5,301			23
24	Travel and Seminar							445	445			24
25	Other Admin. Staff Transportation			10,005	10,005		10,005	3,134	13,139			25
26	Insurance-Prop.Liab.Malpractice			176,122	176,122		176,122	4,715	180,837			26
27	Other (specify):*							43,547	43,547			27
28	TOTAL General Administration	201,816	16,145	1,250,018	1,467,979	19,874	1,487,853	(374,546)	1,113,307			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,604,697	488,583	1,591,714	4,684,994		4,684,994	(325,906)	4,359,088			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number GLENWOOD CARE CENTER #0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			47,221	47,221		47,221	(1,703)	45,518			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			86,333	86,333		86,333	36,357	122,690			32
33	Real Estate Taxes			85,690	85,690		85,690		85,690			33
34	Rent-Facility & Grounds			914,965	914,965		914,965	9,342	924,307			34
35	Rent-Equipment & Vehicles			41,042	41,042		41,042	(6,642)	34,400			35
36	Other (specify):*											36
37	TOTAL Ownership			1,175,251	1,175,251		1,175,251	37,354	1,212,605			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		177,386	132,100	309,486		309,486	(17,979)	291,507			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			111,143	111,143		111,143		111,143			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		177,386	243,243	420,629		420,629	(17,979)	402,650			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,604,697	665,969	3,010,208	6,280,874		6,280,874	(306,531)	5,974,343			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(16,521)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,053)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		25		16
17	Non-Care Related Fees	(150)	20		17
18	Fines and Penalties	(26,822)	21		18
19	Entertainment		20		19
20	Contributions	(400)	20		20
21	Owner or Key-Man Insurance		22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(5,429)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20		28
29	Other-Attach Schedule	(39,078)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (89,453)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(217,078)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (217,078)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (306,531)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

GLENWOOD CARE CENTER

ID# 0040394

Report Period Beginning: 01/01/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	DEFERRED MAINTENANCE	$ 1,977	6	1
2	DIRECTOR OF MARKETING	(41,055)	21	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(39,078)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	1,765	0	0	0	0	0	0	0	0	0	1,765	1
2	Food Purchase	(1,053)	0	0	0	0	0	0	0	0	0	0	(1,053)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	459	0	0	0	0	0	0	0	0	0	459	5
6	Maintenance	1,977	12,356	0	0	0	0	0	0	0	0	0	14,333	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	924	14,580	0	0	0	0	0	0	0	0	0	15,504	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	35,554	0	0	0	0	0	0	0	0	0	35,554	10
10a	Therapy	0	9,736	(12,154)	0	0	0	0	0	0	0	0	(2,418)	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	45,290	(12,154)	0	0	0	0	0	0	0	0	33,136	16
	C. General Administration													
17	Administrative	0	(192,000)	58,594	0	0	0	0	0	0	0	0	(133,406)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	(200,400)	8,256	0	0	0	0	0	0	0	0	(192,144)	19
20	Fees, Subscriptions & Promotions	(5,979)	0	2,735	0	0	0	0	0	0	0	0	(3,244)	20
21	Clerical & General Office Expenses	(67,877)	(121,800)	90,974	0	0	0	0	0	0	0	0	(98,703)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	1,110	0	0	0	0	0	0	0	0	1,110	23
24	Travel and Seminar	0	0	445	0	0	0	0	0	0	0	0	445	24
25	Other Admin. Staff Transportation	0	0	3,134	0	0	0	0	0	0	0	0	3,134	25
26	Insurance-Prop.Liab.Malpractice	0	0	4,715	0	0	0	0	0	0	0	0	4,715	26
27	Other (specify):*	0	0	43,547	0	0	0	0	0	0	0	0	43,547	27
28	**TOTAL General Administration**	(73,856)	(514,200)	213,510	0	0	0	0	0	0	0	0	(374,546)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(72,932)	(454,330)	201,356	0	0	0	0	0	0	0	0	(325,906)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number GLENWOOD CARE CENTER **#** 0040394 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(16,521)	0	14,818	0	0	0	0	0	0	0	0	(1,703)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	36,357	0	0	0	0	0	0	0	0	36,357	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	9,342	0	0	0	0	0	0	0	0	9,342	34
35	Rent-Equipment & Vehicles	0	(15,296)	8,654	0	0	0	0	0	0	0	0	(6,642)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(16,521)	(15,296)	69,171	0	0	0	0	0	0	0	0	37,354	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	(17,979)	0	0	0	0	0	0	0	0	(17,979)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	(17,979)	0	0	0	0	0	0	0	0	(17,979)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(89,453)	(469,626)	252,548	0	0	0	0	0	0	0	0	(306,531)	45

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED SCHEDULE				CAREPLUS MGMT	NILES	MGMT/CLERICAL
				CAREPLUS REHAB	NILES	THERAPY

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	1	DIETARY CONSULT. FEES	$ 7,200	CAREPLUS MANAGEMENT, INC		$	$ (7,200)	1
2	V	17	MANAGEMENT FEES	192,000	" "			(192,000)	2
3	V	19	ADMIN. CONSULT. FEES	186,000	" "			(186,000)	3
4	V	19	DATA PROCESS FEES	14,400	" "			(14,400)	4
5	V	21	CLERICAL FEES	121,800	" "			(121,800)	5
6	V	35	COMPUTER LEASE	15,296	" "			(15,296)	6
7	V	1	DIETARY SALARIES		" "		8,965	8,965	7
8	V	5	ELECTRICITY		" "		459	459	8
9	V	6	MAINT & REPAIRS		" "		1,091	1,091	9
10	V	6	MAINTENANCE SALARIES		" "		11,265	11,265	10
11	V	10	NURSING SALARIES		" "		35,554	35,554	11
12	V	10a	THERAPY SUPPLIES SERVICE		" "		316	316	12
13	V	10a	THERAPY SALARIES		" "		9,420	9,420	13
14	Total			$ 536,696			$ 67,070	$ * (469,626)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY SERVICES	$ 89,301	CAREPLUS REHABILITATIVE SERVICES		$ 77,147	$ (12,154)	15
16	V	39	ANCILLARY THERAPY	132,098	" "		114,119	(17,979)	16
17	V								17
18	V								18
19	V								19
20	V	17	ADMIN. SALARIES		CAREPLUS MGMT, INC.		58,594	58,594	20
21	V	19	PROFESSIONAL FEES		" "		8,256	8,256	21
22	V	20	ADVERTISING		" "		2,735	2,735	22
23	V	21	TOTAL OFFICE		" "		22,818	22,818	23
24	V	21	CLERICAL SALARIES		" "		68,156	68,156	24
25	V	23	SEMINARS		" "		1,110	1,110	25
26	V	24	TRAVEL		" "		445	445	26
27	V	25	TRANSPORTATION		" "		3,134	3,134	27
28	V	26	INSURANCE		" "		4,715	4,715	28
29	V	27	EMPLOYEE BENEFITS		" "		43,547	43,547	29
30	V	30	DEPRECIATION (SL)		" "		14,818	14,818	30
31	V	32	INTEREST		" "		36,357	36,357	31
32	V	34	OFFICE RENT		" "		9,342	9,342	32
33	V	35	EQUIPMENT RENT		" "		8,654	8,654	33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 221,399			$ 473,947	$ * 252,548	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	CAREPLUS MGMT ALLOCATIONS:								$		1
2	SHERWIN RAY	PRESIDENT	ADMIN.FINANC	24.63	SEE ATTACHED	5.6	54.36	SALARY	17,347	17-7	2
3	JAKOB BAKST	DIR OPERATIONS	ADMIN,CONSUL	24.63	SCHEDULE	5.6	54.36		17,347	17-7	3
4	JOE ZIMMERMAN	CFO	CLERICAL	0.99		5.6	54.36		11,192	21-7	4
5	JANICE L. CLAFFORD	CONTROLLER	CLERICAL	0.99		5.6	54.36		4,755	21-7	5
6	ROMY MACASAET	RN CONSULTANT	NURSING	0.49		5.6	54.36		7,974	10-7	6
7	JAMEE O'BRIEN	REGIONAL DIR	ADMINISTRAT	0.49		5.6	54.36		10,175	17-7	7
8	MOSHE POLLAK	DIR OF MAINT	MAINTEN	0.49		5.6	54.36		5,011	6-7	8
9	TOMMY ORR	RN CONSULTANT	NURSING	0.49		5.6	54.36		9,093	10-9	9
10	JOE ANN BREW	REGIONAL DIR	ADMINISTRAT	0.49		5.6	54.36		5,597	17-7	10
11	NORA GORMAN	ADMINISTRATOR	ADMINISTRAT	0.49		40	100.00		49,338	17-1	11
12											12
13								TOTAL	$ 137,829		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPLUS MANAGEMENT, INC.
Street Address: 5940 W. TOUHY
City / State / Zip Code: NILES, IL 60714
Phone Number: (847) 647-1717
Fax Number: (847) 647-0222

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	DIETARY SALARIES	CENSUS DAYS	459,177	9	$ 75,722	$ 75,722	54,363	$ 8,965	1
2	5	ELECTRICITY	CENSUS DAYS	579,760	13	4,894		54,363	459	2
3	6	MAINT & REPAIRS	CENSUS DAYS	579,760	13	11,630		54,363	1,091	3
4	6	MAINTENANCE SALARIES	CENSUS DAYS	579,760	13	120,135	120,135	54,363	11,265	4
5	10	NURSING SALARIES	CENSUS DAYS	579,760	13	379,168	379,168	54,363	35,554	5
6	10a	THERAPY SUPPLIES SERVICE	CENSUS DAYS	579,760	13	3,372		54,363	316	6
7	10a	THERAPY SALARIES	CENSUS DAYS	579,760	13	100,459	100,459	54,363	9,420	7
8	17	ADMIN. SALARIES	CENSUS DAYS	579,760	13	624,886	624,886	54,363	58,594	8
9	19	PROFESSIONAL FEES	CENSUS DAYS	579,760	13	88,050		54,363	8,256	9
10	20	ADVERTISING	CENSUS DAYS	579,760	13	29,166		54,363	2,735	10
11	21	TOTAL OFFICE	CENSUS DAYS	579,760	13	243,348		54,363	22,818	11
12	21	CLERICAL SALARIES	CENSUS DAYS	579,760	13	726,859	726,859	54,363	68,156	12
13	23	SEMINARS	CENSUS DAYS	579,760	13	11,834		54,363	1,110	13
14	24	TRAVEL	CENSUS DAYS	579,760	13	4,741		54,363	445	14
15	25	TRANSPORTATION	CENSUS DAYS	579,760	13	33,425		54,363	3,134	15
16	26	INSURANCE	CENSUS DAYS	579,760	13	50,288		54,363	4,715	16
17	27	EMPLOYEE BENEFITS	CENSUS DAYS	579,760	13	464,414		54,363	43,547	17
18	30	DEPRECIATION (SL)	CENSUS DAYS	579,760	13	158,032		54,363	14,818	18
19	32	INTEREST	CENSUS DAYS	579,760	13	387,734		54,363	36,357	19
20	34	OFFICE RENT	CENSUS DAYS	579,760	13	99,626		54,363	9,342	20
21	35	EQUIPMENT RENT	CENSUS DAYS	579,760	13	92,291		54,363	8,654	21
22										22
23										23
24										24
25	TOTALS					$ 3,710,074	$ 2,027,229		$ 349,751	25

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1							$	$			$	1
2	CIB BANK		X	CAPITAL IMPROVEMENT	$4,739.35	02/01	225,000	155,205	02/06	PRIME+	19,905	2
3	LOAN COSTS		X	LOAN COSTS	W/O OVER 5 YEARS		1,125	712	02/06		225	3
4												4
5												5
	Working Capital											
6	CAREPLUS MGMT INC.	X		WORKING CAPITAL	DEMAND	04/95	1,300,000	1,000,000		PRIME+	60,520	6
7	A. I. CREDIT CORP.		X	INSURANCE FINANCE							5,683	7
8	CAREPLUS MGMT ALLOCATION										36,357	8
9	TOTAL Facility Related				$4,739.35		$ 1,526,125	$ 1,155,917			$ 122,690	9
	B. Non-Facility Related*											
10	IRS, IDR, ETC		X	LATE FEES								10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,526,125	$ 1,155,917			$ 122,690	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 80,260	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 82,562	2
3. Under or (over) accrual (line 2 minus line 1).		$ 2,302	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 83,388	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 85,690	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	71,803	8
	1998	72,032	9
	1999	75,565	10
	2000	79,467	11
	2001	82,562	12

THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL

THE PAYMENT ON LINE 2 APPLIES TO THE 2001 TAX BILL.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME GLENWOOD CARE CENTER COUNTY WILL

FACILITY IDPH LICENSE NUMBER 0040394

CONTACT PERSON REGARDING THIS REPORT BOB KAGDA

TELEPHONE (847) 675-3585 FAX #: (847) 675-5777

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 2001

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	30-07-07-304-025-0000	NURSING HOME	$ 82,562.36	$ 82,562.36
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 82,562.36	$ 82,562.36

B. **Real Estate Tax Cost Allocation**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 80,000 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories 2

C. Does the Operating Entity? [ ] (a) Own the Facility [ ] (b) Rent from a Related Organization. [X] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	NURSING HOME	75,625		$	1
2					2
3	TOTALS	75,625		$	3

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LEASEHOLD IMPROVEMENTS			1993	1,080	34	31.5	34		330	9
10	LEASEHOLD IMPROVEMENTS			1993	26,757	686	39	686		6,479	10
11	LEASEHOLD IMPROVEMENTS			1994	4,980	128	39	128		1,125	11
12	OUTLETS			1995	1,429	37	39	37		270	12
13	PAVING			1995	19,500	1,301	15	1,301		9,756	13
14	ROOF REPAIR			1996	2,505	64	39	64		440	14
15	ELEVATOR REPAIR			1996	7,000	179	39	179		1,216	15
16	WATER CONDITIONING SYSTEM			1996	3,486	89	39	89		597	16
17	ROOFTOP A/C UNIT			1996	5,300	136	39	136		822	17
18	LANDSCAPING			1996	3,554	237	15	237		1,540	18
19	EXTERIOR PLASTER/PAINT			1997	8,500	218	39	218		1,263	19
20	PLUMBING			1997	1,091	28	39	28		158	20
21	LAMINATED COUNTER TOPS			1997	5,900	152	39	152		785	21
22	WALK-IN COOLER			1998	9,893	254	39	254		1,259	22
23	OUTDOOR STORAGE UNIT			1998	1,200	31	39	31		151	23
24	DRAIN LINE REPAIRS			1998	6,575	168	39	168		804	24
25	ROOFTOP HEAT / AC UNIT			1998	5,200	133	39	133		560	25
26	LANDSCAPING			1998	5,883	392	15	392		1,764	26
27	ROOF & HEATING REPAIRS / FIRE SAFETY UPGRADE			1999	17,798	456	39	456		1,450	27
28	NEW SUSPENDED CELLING			2000	64,670	2,351	27.5	2,351		6,669	28
29	CARPET-ENTRANCE & LOBBY			2000	2,750	541	20	138	(403)	414	29
30	NEW DIALYSIS ROOM			2001	8,750	318	27.5	318		596	30
31	INSTALLATION WATER SYSTEM			2001	1,905	69	27.5	69		130	31
32	FIRE ALARM SYSTEM-NEW HORNS,SMOKE DETECTORS			2001	7,194	262	27.5	262		338	32
33	DRYWALL			2001	5,425	197	27.5	197		255	33
34	PASSENGER ELEVATOR-PUMPING UNIT			2001	9,700	353	27.5	353		368	34
35	REPLACE WATER HEATER			2001	4,411	160	27.5	160		167	35
36	ROOF REPAIR			2002	3,100	89	27.5	89		89	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	NURSES STATION WITH SURFACE TRANSACTION TOP	2002	$ 17,820	$ 135	27.5	$ 135	$	$ 135	37
38	VESTIBULE, LOBBY,DINING ROOMS - WALLCOVERING	2002	7,200	192	27.5	192		192	38
39	REPLACE THE ELEVATOR PUMPING UNIT	2002	4,700	135	27.5	135		135	39
40	NURSES' STATIONS-WALLCOVERING, ELECTRIC. WORK	2002	5,440	73	27.5	73		73	40
41	REPAIR PATCH AT FRONT OF BUILDING	2002	1,720	76	15	115	39	115	41
42	BUILD NEW WALL BETWEEN LOBBY & NURSES STATION	2002	6,930	74	27.5	74		74	42
43	LOBBY, VESTIBULE, CORRIDOR-FLOORING	2002	34,654	263	27.5	263		263	43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57	CAREPLUS MGMT INC.: LEASEHOLD IMPROVEMENTS			110		110			57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 324,000	$ 10,121		$ 9,757	$ (364)	$ 40,782	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 193,503	$ 22,365	$ 17,033	$ (5,332)	8-15	$ 83,584	71
72	Current Year Purchases	24,102	10,605	1,370	(9,235)	5-10	1,370	72
73	Fully Depreciated Assets	5,299					5,299	73
74	RELATED PARTY ALLOC SL DEPR		14,708	14,708				74
75	TOTALS	$ 222,904	$ 47,678	$ 33,111	$ (14,567)		$ 90,253	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	1998 CHEVROLET VAN	2001	$ 13,250	$ 4,240	$ 2,650	$ (1,590)	5	$ 5,300	76
77										77
78										78
79										79
80	TOTALS			$ 13,250	$ 4,240	$ 2,650	$ (1,590)		$ 5,300	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 560,154	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 62,039	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 45,518	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (16,521)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 136,335	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: METROPOLITAN NURSING CENTER OF JOLIET

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	1970	203	04/01/93	$ 914,965	30		3
4	Additions							4
5								5
6								6
7	TOTAL		203		$ 914,965 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [X] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$ 933,264
13.	/2004	$ 951,929
14.	/2005	$ 970,968

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 41,042 Description: SEE SCHEDULE ATTACHED
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

THE FACILITY HIRES ONLY CERTIFIED NURSES AIDES

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 63,050	$		$ 63,050	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			946			946	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			68,104			68,104	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				165,536		165,536	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	MEDICAL SUPPLIES Other (specify): LAB/RENTALS	39-2 39-2					120 11,730		120 11,730	13
14	TOTAL			$		$ 132,100	$ 177,386		$ 309,486	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number GLENWOOD CARE CENTER **#** 0040394 **Report Period Beginning:** 01/01/2002 **Ending:** 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/2002 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 68,393	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,643,587		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	68,289		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	96,060		8
9	Other(specify): Real Estate Tax Escrow	78,196		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,954,525	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	324,000		15
16	Equipment, at Historical Cost	236,154		16
17	Accumulated Depreciation (book methods)	(218,553)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds	487,200		21
22	Other Long-Term Assets (specify):			22
23	Other(specify): CAPITAL IMPV LOAN FEES	712		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 829,513	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,784,038	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 842,708	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	34,092		28
29	Short-Term Notes Payable	1,155,205		29
30	Accrued Salaries Payable	137,450		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,486		31
32	Accrued Real Estate Taxes(Sch.IX-B)	83,388		32
33	Accrued Interest Payable	6,865		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,271,194	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 2,271,194	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 512,844	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,784,038	$	48

***(See instructions.)**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 592,088	1
2	Restatements (describe):		2
3	PRIOR YEAR ADJUSTMENT	(17,360)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 574,728	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(61,884)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (61,884)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 512,844	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,210,808	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,210,808	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen	8,095	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 8,095	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	87	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 87	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 6,218,990	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,026,710	31
32	Health Care	2,190,305	32
33	General Administration	1,467,979	33
	B. Capital Expense		
34	Ownership	1,175,251	34
	C. Ancillary Expense		
35	Special Cost Centers	309,486	35
36	Provider Participation Fee	111,143	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,280,874	40
41	**Income before Income Taxes (line 30 minus line 40)****	(61,884)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (61,884)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? NO If not, please attach a reconciliation. TAX RETURN CASH BASIS**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,265	2,337	$ 66,057	$ 28.27	1
2	Assistant Director of Nursing	1,915	2,088	50,181	24.03	2
3	Registered Nurses	13,468	14,622	312,792	21.39	3
4	Licensed Practical Nurses	23,510	25,335	453,176	17.89	4
5	Nurse Aides & Orderlies	77,024	80,153	755,870	9.43	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	6,060	6,297	63,032	10.01	8
9	Activity Director	2,650	2,777	34,416	12.39	9
10	Activity Assistants	8,183	8,660	57,165	6.60	10
11	Social Service Workers	5,981	6,300	103,924	16.50	11
12	Dietician					12
13	Food Service Supervisor	1,825	1,890	27,618	14.61	13
14	Head Cook	2,533	2,786	27,023	9.70	14
15	Cook Helpers/Assistants	16,119	16,919	119,934	7.09	15
16	Dishwashers					16
17	Maintenance Workers	4,088	4,174	53,801	12.89	17
18	Housekeepers	24,641	26,109	197,686	7.57	18
19	Laundry	7,951	8,413	59,765	7.10	19
20	Administrator	1,851	2,155	67,108	31.14	20
21	Assistant Administrator	1,827	1,985	28,685	14.45	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	3,914	4,078	64,968	15.93	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,188	2,241	20,441	9.12	31
32	Other Health Care(specify)					32
33	Other(specify) MARKETING	1,991	2,088	41,055	19.66	33
34	TOTAL (lines 1 - 33)	209,984	221,407	$ 2,604,697 *	$ 11.76	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	M	$ 7,200	1-3	35
36	Medical Director	O	14,400	9-3	36
37	Medical Records Consultant	N	0	10-3	37
38	Nurse Consultant	T	0	10-3	38
39	Pharmacist Consultant	H	300	10-3	39
40	Physical Therapy Consultant	L	7,200	10a-3	40
41	Occupational Therapy Consultant	Y	7,200	10a-3	41
42	Respiratory Therapy Consultant		0	10a-3	42
43	Speech Therapy Consultant	F	0	10a-3	43
44	Activity Consultant	E	0	11-3	44
45	Social Service Consultant	E	2,727	12-3	45
46	Other(specify)	S			46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 39,027		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	9	$ 1,337	10-3	50
51	Licensed Practical Nurses	43	3,661	10-3	51
52	Nurse Aides			10-3	52
53	TOTAL (lines 50 - 52)	52	$ 4,998		53

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NORA GORMAN	ADMIN	0.49	$ 49,338
MICHAEL TORAL	ADMIN	0	17,770
ELIMELECH RAY	ASST ADMIN	0	13,036
HELENA MATHEWS	ASST ADMIN	0	15,649
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 95,793

B. Administrative - Other

Description		Amount
CAREPLUS MGMT INC	MANAGEMENT FEES	$ 192,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)		$ 192,000

C. Professional Services

Vendor/Payee	Type	Amount
CAREPLUS MGMT	DATA PROCESSING	$ 14,400
HDSI	DATA PROCESSING	1,696
AMERICAN DATA	DATA PROCESSING	1,835
NATIONAL DATACARE	DATA PROCESSING	1,096
CAREPLUS MGMT	ADMIN. CONSULTANT	186,000
KBKB	ACCOUNTING FEES	26,550
MEYER MAGENCE	LEGAL FEES	8,324
SACHNOFF & WEAVER	LEGAL FEES	851
ECONOCARE	PURCHASE CONSULT	1,827
PERSONNEL PLANNERS	U C CONSULT	2,696
RICHARD PEELO	MEDICARE CONSULT	3,750
C. LTD CONSULTING	PLAN OF CORRECTION	2,114
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 251,139

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,280
Unemployment Compensation Insurance	25,171
FICA Taxes	196,809
Employee Health Insurance	101,307
Employee Meals	19,874
Illinois Municipal Retirement Fund (IMRF)*	
EMPLOYEE BENEFITS - OTHER	1,884
EMPLOYEE PHYSICAL EXAMS	0
PENSION/PROFIT SHARING PLANS	26,699
CHICAGO HEAD TAX	0
INSURANCE - EXECUTIVE LIFE	0
INSURANCE - EXECUTIVE LIFE VI 21	0
TOTAL (agree to Schedule V, line 22, col.8)	$ 421,024

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	30,510
Health Care Worker Background Check	0
(Indicate # of checks performed)	
MARKETING/ADV/PROMO	5,429
TRUST/FRANCHISE/CONTRIB/ETC	550
LICENSES & PERMITS	2,215
DUES & SUBSCRIPTIONS	11,272
MGMT CO ALLOCATION	2,735
TRUST/FRANCHISE/CONTRIB/ETC	(550)
Less: Public Relations Expense	(0)
Non-allowable advertising	(5,429)
Yellow page advertising	(0)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 46,932

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	0
MGMT CO ALLOCATION	445
Seminar Expense	0
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 445

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1	PAINTING/DECORATIN	1999	$ 10,434	3 YRS	$ 1,739	$ 3,478	$ 3,478	$ 1,739	$	$	$	$	$
2	PAINTING/DECORATIN	2000	8,643	3 YRS		1,440	2,881	2,881	1,441				
3	PAINTING/DECORATIN	2002	3,172	3 YRS				529	1,057	1,057	529		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 22,249		$ 1,739	$ 4,918	$ 6,359	$ 5,149	$ 2,498	$ 1,057	$ 529	$	$

Facility Name & ID Number GLENWOOD CARE CENTER # 0040394 Report Period Beginning: 01/01/2002 Ending: 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **YES**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL COUNCIL LONG TERM CARE $10,597**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **NO**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YR**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,478** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **111,143**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **19,874** Has any meal income been offset against related costs? **N/A** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **5%**
d. Have vehicle usage logs been maintained? **NO**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **NO**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **YES**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.

Facility Name & ID#: GLENWOOD CARE CENTER #0040394 **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
1	**DIETARY**			
	DIETITIAN CONSULTANT	XVIII B 35-2	7,200	
	REPAIRS & MAINTENANCE		6,640	
			0	13,840
3	**HOUSEKEEPING**			
			0	
			0	0
4	**LAUNDRY**			
	EQUIPMENT REPAIRS & MAINTENANCE		0	
			0	0
5	**HEAT & OTHER UTILITIES**			
	GAS HEAT		15,786	
	ELECTRICITY		91,629	
	WATER		51,618	
	CABLE TV - LOBBY		0	
			0	159,033
6	**MAINTENANCE**			
	GROUNDS MAINTENANCE		7,095	
	PAINTING & DECORATING		3,172	
	BUILDING REPAIRS			
	MAINTENANCE TRAVEL			
	EQUIPMENT MAINTENANCE & REPAIR		14,044	
	ELEVATOR MAINTENANCE & REPAIR		5,404	
	OUTSIDE LABOR		0	
	EXTERMINATING SERVICE		2,594	
	FIRE SERVICE		6,313	
			0	
			0	
			0	38,622
7	**OTHER**			
	SCAVENGER		15,474	
	SECURITY SERVICE		0	15,474
9	**MEDICAL DIRECTOR**			
	MEDICAL DIRECTOR FEES	XVIII B 36-2	14,400	14,400

LINE		SCHED REF		TOTAL
10	**NURSING**			
	CONTRACT NURSING	XVIII C 53-2	4,998	
	LABORATORY & XRAY EXPENSE		0	
	PURCHASED SERVICES		0	
	PSYCHO-SOCIAL CONSULTANT	XVIII B __-2	0	
	RESTORATIVE NURSING CONSULTAN	XVIII B 38-2	0	
	MEDICAL RECORDS CONSULTANT	XVIII B 37-2	0	
	PHARMACY CONSULTANT	XVIII B 39-2	300	
	UTILIZATION REVIEW FEES	XVIII B __-2	0	
	PHYSICIANS	XVIII B __-2	0	
	PSYCHIATRIC	XVIII B __-2	0	
	RN CONSULTANT	XVIII B 38-2	0	
	DENTAL SERVICE		3,000	
			0	8,298
10a	**THERAPY**			
	PHYSICAL THERAPY SERVICES		26,433	
	SPEECH THERAPY SERVICES		3,146	
	OCCUPATIONAL THERAPY SERVICES		22,128	
	THERAPY CONTRACT SERVICES		23,195	
	PHYSICAL THERAPY CONSULTANT	XVIII B 40-2	7,200	
	OCCUPATIONAL THERAPY CONSULTA	XVIII B 41-2	7,200	
	RESPIRATORY THERAPY CONSULTAN	XVIII B 42-2	0	
	SPEECH THERAPY CONSULTANT	XVIII B 43-2	0	89,302
11	**ACTIVITIES**			
	CABLE TV - PATIENT ROOMS		0	
	ACTIVITY REHAB CONSULTANT	XVIII B 44-2	0	
			0	0
12	**SOCIAL SERVICES**			
	SOCIAL REHABILITATION SERVICES		0	
	SOCIAL REHABILITATION CONSULTAN	XVIII B 45-2	0	
	SOCIAL WORKER	XVIII B 45-2	2,727	
			0	2,727
13	**NURSE AIDE TRAINING**			
	NURSE AIDE TRAINING COSTS	XIII	0	0

Facility Name & ID Number GLENWOOD CARE CENTER **#0040394** **Report Period Beginning: 01/01/2002** **Ending: 12/31/2002**

V.COST CENTER EXPENSES **PAGE 3 COLUMN 3 OTHER**

LINE		SCHED REF		TOTAL
14	**PROGRAM TRANSPORTATION**			
	PATIENT TRANSPORTATION		0	0
17	**ADMINISTRATIVE**			
	MANAGEMENT FEES	XIX B	192,000	192,000
18	**DIRECTORS FEES**		0	0
19	**PROFESSIONAL SERVICES**			
	DATA PROCESSING	XIX C	19,027	
	ADMINISTRATIVE CONSULTANTS	XIX C	186,000	
	PROFESSIONAL FEES	XIX C	46,112	
			0	251,139
20	**FEES,SUBSCRIPTIONS,PROMOTIONS**			
	ENTERTAINMENT & MARKETING	VI 19 XIX F	0	
	ADV & PROMO-NON PATIENT RELATED	VI 25 XIX F	5,429	
	EMPLOYEE WANT ADS	XIX F	30,510	
	CONTRIBUTIONS	VI 20 XIX F	400	
	DUES & SUBSCRIPTIONS	XIX F	11,272	
	LICENSES & PERMITS	XIX F	2,415	
	PUBLIC RELATIONS-PATIENT RELATED	XIX F	0	
	ADVERTISING-YELLOW PAGES	VI 28 XIX F	0	
	TRUST FEES / FRANCHISE TAX / ETC	VI 17 XIX F	150	
	CONTRIBUTIONS - POLITICAL	VI 20 XIX F	0	
	HEALTH CARE WORKER BACKGROUND CHEC	XIX F	0	50,176
21	**CLERICAL & GENERAL OFFICE EXPENSES**			
	BANK CHARGES (INCLUDES NO OVERDRAFT CHARGES)			
	EQUIPMENT REPAIR & MAINTENANCE		3,844	
	OUTSIDE CLERICAL SERVICES		121,800	
	PENALTIES / OVERDRAFT CHARGES	VI 18	21,316	
	HOME OFFICE EXPENSE		0	
	THEFT & DAMAGE LOSS		0	
	TELEPHONE		17,387	
	MESSENGER SERVICE		888	
			0	165,235

LINE		SCHED REF		TOTAL
22	**EMPLOYEE BENEFITS & PAYROLL TAXES**			
	FICA TAXES	XIX D	196,809	
	UNEMPLOYMENT COMPENSATION	XIX D	25,171	
	WORKERS COMPENSATION INSURANC	XIX D	49,280	
	HOSPITALIZATION INSURANCE	XIX D	101,307	
	EMPLOYEE BENEFITS - OTHER	XIX D	1,884	
	EMPLOYEE PHYSICAL EXAMS	XIX D	0	
	INSURANCE - EXECUTIVE LIFE	VI 21/XIX D	0	
	UNION PENSION FUND/401 K EXPENSE	XIX D	26,699	
	CHICAGO HEAD TAX	XIX D	0	401,150
23	**INSERVICE TRAINING & EDUCATION**			
	EDUCATION & SEMINARS		4,191	4,191
24	**TRAVEL & SEMINARS**			
	EDUCATION & SEMINARS	XIX G		
	TRAVEL	XIX G	0	
			0	
			0	0
25	**ADMIN. STAFF TRANSPORTATION**			
	TRANSPORTATION - STAFF		10,005	10,005
26	**INSURANCE - PROP. LIAB & MALPRACTICE**			
	GENERAL INSURANCE		176,122	176,122
27	**OTHER**			
	BAD DEBTS	VI 24	0	
			0	0

GRAND TOTAL COLUMN 3 OTHER 1,591,714

GLENWOOD CARE CENTER
EMPLOYEE MEAL RECLASSIFICATION
12/31/2002

TOTAL FOOD PURCHASE	217,413
LESS SALES TAX	(1,053)
NET FOOD	216,360
TOTAL PATIENT CENSUS	54,363
TIME 3 MEALS PER DAY	3
TOTAL PATIENT MEALS	163089
ADD # EMPLOYEE MEALS/DAY	45
TIME # DAYS	365
TOTAL EMPLOYEE MEALS	16425

PATIENT MEALS	163089
ADD EMPLOYEE MEALS	16425
TOTAL MEALS/YEAR	179514
NET FOOD	216360
DIVIDE TOTAL MEALS/YEAR	179514
COST PER MEAL	1.21
TIME EMPLOYEE MEALS	16425
EMPLOYEE MEAL RECLASSIFICATION	19874